Refer to: Where we stand on drug abuse—Statement by the California Medical Association Committee on Alcoholism and the Committee on Dangerous Drugs. Calif Med 118: 58-64, June 1973

Where We Stand on Drug Abuse

FOREWORD . . .

IMPROPER USE OF ANY DRUG IS A HEALTH AND MEDICAL PROBLEM FIRST

When a person shows medical indications of physical or psychological dependence on any drug, that person should receive competent medical care. All physicians, all hospitals and all health insurance carriers should assume their respective responsibilities for medical management of the alcoholic and drug dependent patient. Therefore, we urge physicians to seek training and practical experience in the techniques of diagnosis and treatment associated with drug abuse problems including alcoholism. We urge the establishment of training programs in medical schools, in community hospitals and at postgraduate levels with extension of training to nurses and paramedical personnel.

We urge that physicians fully understand the legal rights and status of the patients, as well as their own legal responsibility in treating patients who are drug users. Where laws, local ordinances, rulings or procedures interfere with providing necessary care or violate patient-physician confidentiality, all resources of the medical profession and the public should be directed toward eliminating this interference.

Flexibility of attitudes on all sides of the issues, positive changes in laws and changes in some existing enforcement procedures will be required to meet the problems created by the improper use of drugs.

NOTE: The sections of this report which reiterate basic factual information are shown in standard type. *The sections which represent a position, or which tell where we stand, are shown in italics.*

THE DRUGS OF ABUSE are defined as those drugs which produce mood alteration or mind alteration —those drugs which are psychoactive.

The term drug abuse will be understood to mean the use of any drug by an individual to the extent that it adversely affects or limits his ability to function as a responsible person.

Methods of categorizing or ranking the drugs of abuse depend upon the purpose and the criteria of the classifier. We recognize that all such rankings are somewhat arbitrary, and that many variable factors such as different age and socio-economic groups, different geographical locations and the percentage of the population involved could alter the order of such a list.

For example, when drugs are placed in a rank order primarily on the basis of physical organ damage, current information would suggest that they be listed in this order, beginning with the most damaging:

1. alcohol
2. tobacco
3. amphetamines
4. solvents
5. barbiturates
6. heroin and other narcotics (in their pharmacologically pure form)
7. cocaine
8. hallucinogens
9. hashish
10. marijuana
11. caffeine

This statement was prepared by the California Medical Association Committee on Alcoholism and the Committee on Dangerous Drugs, endorsed by the Scientific Board and the Council, and accepted by the House of Delegates, March 10-14, 1973.

Reprint requests to: California Medical Association, Attention: Gail B. Jara, 693 Sutter Street, San Francisco, Ca. 94102.

For this paper, however, it seems more appropriate to rank the drugs of abuse in the approximate order of their physical damage, psychological and socio-economic disruption taken together. The order then is:

1. alcohol
2. barbiturates
3. amphetamines
4. heroin and other narcotics (in their adulterated, contaminated form available for street use)
5. cocaine
6. hallucinogens
7. marijuana and hashish
8. solvents
9. tobacco

Alcohol

Alcohol in all its forms is a drug of the sedative hypnotic class[1] which is fully available (in fact, advertised) and whose social use is widespread. The extent of use and the effects vary from person to person.

Acute short-term alcohol intoxication, chronic use short of alcoholism and alcoholism itself each represents a serious form of drug abuse. When evaluated in terms of organ damage, the effect on the user's overall health, societal disruption, association with criminal behavior or total population involved, alcohol abuse is the most serious form of drug abuse in our society today—*even more serious than heroin addiction.*

The California Medical Association's Committee on Alcoholism has defined alcoholism as a chronic disabling disease of unknown cause, characterized by physiological, psychological or socio-economic disturbances in a person that impair his ability to function in a normal, acceptable manner within his environment.

Diagnosis of alcoholism should not be based on the amount of alcohol ingested, but rather on the disruptive effect of whatever amount is taken. The diagnosis of alcoholism is difficult to document; however, these major and minor symptoms have been defined.

Major symptoms of alcoholism:

1. in some persons, the occurrence of severe withdrawal syndrome; that is, the appearance, within a few hours of the last drink, of symptoms (such as, severe tremulousness, alcoholic hallucinations, withdrawal seizures or convulsions, delirium tremens)[2] which interfere with the ability of the person to function or to meet the responsibilities of the moment;

2. in some persons, the fact that they do not appear to be intoxicated despite very high blood levels of alcohol;

3. continued drinking despite strong medical reasons not to, or social reasons such as the loss of a job or spouse.

Minor symptoms of alcoholism:

1. results of certain laboratory tests demonstrating liver damage or other chemical derangements;

2. surreptitious drinking;

3. frequent automobile accidents or traffic violations;

4. drinking to relieve anger, insomnia or depression;

5. repeated attempts to "go on the wagon," with failure.

Generally speaking, a diagnosis of alcoholism is strongly indicated when any one of the major symptoms is present, or any combination of two or more of the minor symptoms. Such findings should lead to further diagnostic probing in order to establish the diagnosis of alcoholism.

The treatment of alcoholism falls into at least three phases. The patient is detoxified or treated for the acute state of intoxication (first phase). In the chronic alcoholic, this detoxification may be followed by relatively severe withdrawal symptoms which must then be treated (second phase). Long term treatment (third phase) is usually designed to achieve the abstention from all alcoholic beverages. The physician should be prepared to give pharmacological as well as psychological support as needed during these phases of treatment.

The California Medical Association recognizes the use of alcohol as one of the most destructive forms of drug abuse in our society today. CMA does not advocate prohibition of alcoholic beverages. It does advocate intensive public education, in all grade levels and through the mass media, concerning the harmful effects of alcohol. Since there are widespread advertisements promoting the use of alcohol in its various forms, the mass media should be careful not to present alcohol in such a fashion as to promote its use as a mood-altering drug.

1. Alcohol compounds the effects of other sedative hypnotic drugs such as barbiturates and may have more serious effects when taken in such combinations.

2. Severe withdrawal symptoms need not occur after every drinking episode.

Alcoholism must be recognized and treated as a disease which has become a public health concern of major proportions—challenging heart disease, stroke and cancer as the Number One health problem of the country. The application of specific criteria for the diagnosis of alcoholism should help correct a current imbalance, namely, over-diagnosis among members of the lower socio-economic groups and under-diagnosis in the middle and upper income groups.

CMA recommends that insurance coverage should no longer exclude the treatment of alcoholism or place restrictions on the coverage provided, except as they may apply to any other medical illness.

Barbiturates, Other Sedative Hypnotics and "Minor" Tranquilizers

Examples of barbiturates, other sedative hypnotics and "minor" tranquilizers are:[3]

secobarbital, Seconal®, "reds;"
pentobarbital, Nembutal®, "nembies, yellows, yellow jackets;"
amobarbital, Amytal®, "blues, blue heavens;"
combination amobarbital and secobarbital, Tuinal®, "rainbows;"
phenobarbital, Luminal®, "phennies;"
methaqualone, Quaalude®, Sopor®, "sopors;"
meprobamate, Miltown®, Equinil®, "mother's little helpers;"
diazepam, Valium®, "vals;"
chlordiazepoxide, Librium®, "libs."

This whole group of drugs is collectively known as barbs, downers, goofers, sleepers, and other such terms.

Barbiturates are central nervous system depressants used for treatment of insomnia and relief of anxiety. Continued use produces tolerance and physiological addiction as well as psychological dependence on the effects of the drugs. Doses higher than the individual's tolerance produce a state of deep anesthesia which is followed by respiratory and circulatory depression.[4] Overdose can be fatal.

A problem as grave as acute intoxication and overdose is chronic barbiturate use, which resembles one of the major symptoms of chronic alcoholism—that is, signs of intoxication are not present even when large amounts of barbiturates are present in the body.

Withdrawal from heavy barbiturate use can present a major medical emergency for which hospitalization is often required because of convulsions (sometimes resulting in compression fractures of the spine and possibly death), lack of oxygen or accumulation of abnormally large amounts of fluid in the lungs or brain may result in death. Extensive care after withdrawal is usually required to establish personal stability and to replace the psychological dependence.

The "minor" tranquilizers are drugs ordinarily prescribed to relieve anxiety. Continued use in larger than usual doses produces a dependency.

Physicians should be aware of the abuse potential (addiction potential) before they place a patient on any of these drugs.

Amphetamines

Examples of drugs classified as amphetamines are:

amphetamine, Benzedrine®, "bennies, cross tops, whites;"
methamphetamine, Methedrine®, Desoxyn®, "meth, crystal, speed, beans;"
dextroamphetamine, Dexadrine®, "dexies;"
dl-amphetamine resin, Biphetamine®, "black beauties;"
combination of dextroamphetamine and amobarbital, Dexamyl®, "Christmas trees."

This whole group of drugs is collectively known as uppers, speed, pep pills, et cetera.

Amphetamines are central nervous system stimulants used in the treatment of certain hyperactive neurologically impaired children and in the treatment of narcolepsy. They have also been used to suppress the appetite, elevate the mood and ward off fatigue. Such use sometimes leads to abuse patterns.

People who continually take larger amounts because of increasing tolerance experience extreme psychological dependence and may suffer mild physical withdrawal symptoms when deprived of the drug.

Heavy use of illicitly manufactured or distributed amphetamines (particularly intravenous use) produces some of the more extreme examples of abnormal behavior and erratic mind alteration. Self-destruction, criminal and psychotic behavior are so commonly associated with abuse of stimulants that we feel positive legislative and public health measures are justified in order to control their traffic.

Their use for military and athletic purposes should be thoroughly investigated and submitted to critical analysis.

The continued use of amphetamines for pur-

3. For each classification of drug, several examples are cited by generic term, trade name and street name, in that order. These lists are meant only as representative examples and cannot be considered exhaustive because street names change continuously and new drugs come into use. Furthermore, street names vary in different areas of the state.

4. In combination with any other central nervous system depressant, such as alcohol, the effects are intensified.

poses other than treatment of properly diagnosed narcolepsy or hyperkinesis in children should have clear medical justification. This policy is an essential step toward reducing the excessive manufacture and distribution of these drugs.

Narcotics or Opiates

Examples of narcotics or opiates are:

diacetylmorphine, heroin, "junk, smack, horse, cheeva;"
morphine, "morf, white stuff, Miss Emma;"
methadone, Dolophine®, "dollies, dolls, J-72's, biscuits;"
hydromorphone, Dilaudid®;
meperidine, Demerol®;
oxycodone, Percodan®, "percs, endos;"
methylmorphine, codeine, "fours, schoolboy;"
opium alkaloids, opium, "O, black stuff, hop;"
camphorated tincture of opium, paregoric;
hydrocodone, Hycodan®.

Narcotics are drugs which are prescribed for the relief of pain and also for sedation and sleep. Continued use of heroin or other narcotics produces increasing tolerance, addiction and a strong psychological dependence on the effects of the drug. In the addict with high tolerance, the use of heroin does not necessarily produce either a "rush" or euphoria, but rather is required to maintain normal functioning and to stave off the symptoms of withdrawal.

The narcotics themselves, in their pharmacologically pure form, produce little or no organ damage. The injurious effects to the individual and society are due not to the chronic action of the drugs on the body, but to the hazards which accompany their illegality and the addict's life style—for example, risk of poisoning by adulterants mixed with the drug by the supplier (dealer), risk of blood borne infections (such as hepatitis) from use of dirty or shared needles, risk of overdose from unknown or varying strengths of the drugs, and often the addict's poor hygiene and health habits.

Irrespective of how it develops, once addiction is established, it is a disease which requires medical services and social rehabilitation. The medical aspects of the disease (including medical records, which must be held confidential) must be separated from the criminal aspects of the behavior and legal status of the individual patient, so that treatment may be readily available to every addict who seeks it.

In- and out-patient detoxification to treat withdrawal symptoms (both with and without narcotics such as methadone), half-way houses or living groups which provide surrogate families and peer pressure, and methadone maintenance should all be available in sufficient numbers. They have all been successful to some degree in the treatment of patients addicted to heroin.

In a properly structured methadone maintenance program, the administered methadone itself is only a part of the more complete and complex therapeutic and rehabilitative regime. Adequate attention must be given to these resocialization activities in order to establish personal stability and to replace the psychological dependence on the drug. The ultimate aim of the use of methadone as a treatment tool—as is the aim of the other treatment modalities mentioned above—is to enable the patient to lead a stable, drug-free life.

The fact that addiction to methadone is produced during the period of maintenance and the potential diversion of methadone to street use are both recognized as disadvantages of these programs. Nevertheless, for many addicts such treatment programs become a practical, though not ideal, alternative to the criminalization phase of their addiction.

A uniformly successful treatment modality is not presently available; therefore, we encourage responsible investigation toward this end, and we oppose any governmental regulation or professional rigidity which would promote or require any single modality at the expense of others—whether proven or experimental.

Cocaine

Cocaine is also known by such names as snow, "C", coke, flake, Bernice, nose candy, rich man's drug, snuff and snow bird.

Cocaine is an ancient drug—a stimulant distilled from the coca plant. It is used medically as a topical anesthetic. At present we are witnessing an increase in the illicit use of cocaine for central nervous system stimulation. The effect is similar to that of amphetamines. Cocaine does not require a constantly increasing dose to achieve the desired effect, and discontinuance does not lead to a withdrawal syndrome. Repeated application of cocaine to the nasal membrane for rapid absorption may lead to destruction of the nasal septum.

Strong warnings should be issued that continued usage leads to deterioration of health because of nervous fatigue, nutritional deficiency and psychosocial defects. Psychological dependence is the rule in the habitual user.

Hallucinogens or Psychedelics

Examples of hallucinogens or psychedelics are:

lysergic acid diethylamide, LSD, "acid, sugar, cubes;"
phencyclidine, PCP, "angel's dust, hog, peace pill, elephant"—often misrepresented as THC;
trimethoxyphenethylamine, mescaline, "mesc, big chief, cactus, peyote;"
psilocybin, "mushroom, silly putty;"
STP (DOM), "serenity-tranquility-peace pill;"
DMT, "businessman's special;"
tetrahydrocannabinol, THC.

Hallucinogens are chemicals, or drugs, whose name indicates that they produce hallucinations, or more often, illusions. Continued use does not produce physiological addiction, but does often result in psychological dependence on the effects of the drugs. Little physical damage to organs is attributed to the pharmacological action. Nevertheless, damage to health and the results of aberrant behavior while the user is under the influence of the chemical are very real dangers.

There should be intense scientific investigation to discover the long range effects of hallucinogens, their potential social uses, their value as tools in clinical medical practice and their value in the investigation of the physiology of the central nervous system. However, unsupervised and indiscriminate use of these drugs should be vigorously discouraged.

Marijuana and Hashish

Marijuana, or cannabis sativa, is also known as pot, hay, grass, bush, dope, weed, tea, et cetera. Marijuana cigarettes are known as joints; the small end of such a cigarette left after most of it has been smoked is called a roach.

Hashish is a more potent agent made from the resin of the marijuana plant.

Marijuana is a psychoactive agent whose principal known ingredient, tetrahydrocannabinol (THC), produces sedative and hypnotic effects which can alter a person's mood and behavior to varying degrees—depending on such factors as dose and the setting in which it is taken. It is not a narcotic.

The full range of marijuana's action is currently undergoing intensive scientific investigation. The major consistently observable physical effects in low doses of marijuana use are reddening of the eyes and increase in heart rate. The smoke is irritating to the mucous membranes it reaches. In low doses, its principal actions involving brain functions are subjective; they are described variably as illusion, sensory changes and short-term memory loss.

Long-term effects are not yet known. However, our experience with the long-term effects of drugs such as alcohol, barbiturates and tobacco leads us to anticipate the possibility of physical or psychic damage, unless prolonged years of observation and evaluation exclude such damage.

The California Medical Association encourages research and clinical trials to determine the effects of marijuana's action. CMA feels that, if such research shows marijuana or its active ingredients to have therapeutic properties useful for medical purposes, these substances should be made available for such purposes.

As with other drugs, the exact classification of marijuana in the laws regulating controlled substances should be based on accurate pharmacological definition and accepted research data. Marijuana is not a narcotic. It is hoped that those responsible for legislation will respond to the definition of marijuana as it was stated by the National Commission on Marijuana and Drug Abuse.

The act of legalizing marijuana is one which society must ultimately decide. We do feel that it is the role of the medical profession to provide the scientific facts and interpretations on which such a decision can be based.

On the other hand, the question of reduction of penalties in cases of marijuana use might well be reviewed in light of its medical implications as a primary health issue. The current penalties for the possession of marijuana for personal use, even in private, have imposed criminal status on many persons who otherwise have evidenced no criminal or anti-social behavior. The effects of imprisonment on one's mental and physical health and the effect of a felony conviction on one's future career and emotional stability are among the several health factors to be considered when judging the merits of decriminalization of marijuana. Consequently, the California Medical Association recommends the appropriate reduction of penalties for possession of marijuana for personal use.[5]

There is a certain paradox in advocating decriminalization because of the difficulty of identifying the place at which the possession or transfer of marijuana becomes a criminal act.

5. We refer the reader also to the position of the American Medical Association's House of Delegates (1972) and to the position of the AMA's Committee on Alcoholism and Drug Dependence (1972).

However, the health issue inherent in imprisonment and conviction is an important one, and one on which CMA can take a medical position. As a logical extension of that medical position, comes our advocacy of reduction of penalties.

Solvents and Other Inhalants

Inhaling the fumes of solvents (volatile hydrocarbons such as airplane glue and paint thinner) produces effects ranging from mild intoxication, to acute disorientation, to death. Continued use is responsible for toxic effects upon the brain, kidneys, liver and bone marrow.

Repeated use should call attention to the psycho-social problems of the user, and those problems should be treated medically. The dangers of experimentation must be countered by education.

Tobacco

Tobacco is only minimally psychoactive, is fully available (in fact, advertised) and is not generally considered a drug of abuse. However, most people are now aware of the direct correlation between cigarette smoking and lung cancer. Even more significant, in numbers of people killed and disabled, are cardiovascular disease, bronchitis, and other chronic pulmonary disease caused by cigarettes. Cigarette smoking not only contributes to but may be the direct cause of many of these problems.

While supporting each person's right to freedom of choice, the California Medical Association condemns the use of tobacco as one of the most physically destructive forms of drug abuse in our society today. We recognize that the rights of the non-smoker to breathe air free of cigarette smoke should be given appropriate consideration.

Since much of the damage produced by smoking is potentially reversible, we encourage individuals to give up the smoking habit, and we applaud the efforts to develop treatment modalities aimed at curing tobacco habituation.

We advocate intensive public education in all grade levels and through the mass media concerning the harmful effects of smoking.

Prescription Drugs

Almost all the examples listed under the sections on barbiturates, narcotics and amphetamines are prescription drugs that can be abused either licitly, by prescription, or illicitly by using an altered prescription or obtaining the drug from the black market or the street.

Any drug that is capable of inducing changes in mood or altered states of consciousness is potentially a drug of abuse. The abuse of legally manufactured drugs intended for medical treatment has become a serious problem in recent years.

We strongly recommend that drug manufacturers, drug wholesalers and pharmacists, who are responsible for large quantities of dangerous drugs or drugs with abuse potential, make the utmost effort to insure that these drugs are directed only to legitimate therapeutic uses. The physician should use great care regarding the size of the drug prescription and his refill procedures in order to avoid possibilities for abuse. The public should guard against the use of a prescription drug by anyone other than the person for whom it was prescribed, thus preventing opportunities for abuse and protecting children from possible poisoning.

We encourage signed letters of complaint to the local county medical society and to the Board of Medical Examiners[6] documenting specific instances of misuse of drug prescription practices by a patient or physician.

Over-the-Counter Drugs

Some drugs available over-the-counter are used for psychoactive effects and are thus subject to abuse patterns; for example, cough syrups containing either detromethorphan or low doses of codeine, such as Robitussin-DM® or Romilar® and sedatives such as Nervine®, Compoz®, Sleep-Eze®, Nyquil®.

The public has a right to purchase and self-administer certain drugs that have a wide margin of safety without resorting to medical advice. However, such drugs dispensed over the counter (O.T.C.) without prescription are frequently misused. Drugs for pain relief, asthmatic attacks, hemorrhoids, itching, hyperacidity, constipation, etc. are advertised and dispensed O.T.C. and often self-administered as a substitute for proper medical care of the primary cause of these ailments.

California Medical Association wishes to direct attention to the advertising policies of some of the manufacturers of these drugs. The effects of psychoactive drugs, such as those which maintain wakefulness or induce sleep, are exaggerated. The basic ingredients of most psychoactive drugs on

6. Board of Medical Examiners, 1020 "N" Street, Room 434, Sacramento, California 95814.

the market tend to vary little, but advertising claims imply great advantages of one over the other.

It may be the right of drug manufacturers to so advertise; however, the right to use federally licensed media to disseminate unsubstantiated or exaggerated claims should be prohibited, or such advertising should be closely monitored for accuracy.

The repetitive recommendations in the advertising of O.T.C. drugs tend to reinforce the drug orientation of this society, as well as to reinforce the human urge to overcome internal conflicts and external pressures by taking a pill.

Multiple Drug Use

Many persons use several drugs together, in abuse patterns. A common example is the use of "downers" such as barbiturates or heroin by those who use large amounts of amphetamines or cocaine. The downers are used to counteract the undesirable prolonged effects of the stimulants. Another pattern is the combination of alcohol with barbiturates, which may be additive in their effects. This is an especially dangerous combination because the two sedative hypnotics intensify the effects of one another in a synergistic relationship and can easily result in severe physiological changes such as respiratory depression, coma or possible death from overdose.

We endorse vigorous education efforts to advise the public of the compound dangers which result from this drug taking practice.

Conclusion

Drug abuse—with the many factors contributing to it—is not a single issue but a collection of many complex, inter-related psychological, physical and social problems not isolated from the other problems of our communities; such as, employment, housing, education, police relations. Since many aspects of these problems are unique in each locality, local action and involvement are necessary to confront them.

California Medical Association recommends the establishment of sound, comprehensive treatment programs in which the whole community actively contributes to the social readjustment of the patient.

Sources of pamphlets and other informational materials are:

American Medical Association, 535 North Dearbon Street, Chicago, Illinois 60610

American School Health Association, P.O. Box 416, Kent, Ohio 44240

American Social Health Association, 785 Market, San Francisco, California 94103, or 1740 Broadway, New York, New York 10019

California Blue Shield: Pamphlet: *Drug Abuse: The Chemical Cop Out*, 1969, 720 California Street, San Francisco, California 94108

DARE (Drug Abuse Research and Education), UCLA Neuropsychiatric Institute, 760 Westwood Plaza, Los Angeles, California 90024

Haight-Ashbury Publications, P.O. Box 27278, San Francisco, California 94127

National Clearinghouse for Drug Abuse Information, P.O. Box 1701, Washington, D.C. 20013

National Clearinghouse on Smoking and Health, Health Services and Mental Health Administration, 5600 Fishers Lane, Rockville, Maryland 20852

National Institute on Alcohol Abuse and Alcoholism, 5600 Fishers Lane, Room 6C 15, Rockville, Maryland 20852

The following is a short listing of references given here only to indicate some sources of further information. These references will provide additional bibliographies.

First Special Report to the U.S. Congress on Alcohol and Health from the Secretary of Health, Education and Welfare, December, 1971. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, price $1.50, stock number 1724-0193

Marijuana: A Signal of Misunderstanding—First Report of the National Commission on Marijuana and Drug Abuse, March, 1972. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, $1.00 (paper cover), stock number 5266-0001

Appendix to Marijuana: A Signal of Misunderstanding, Volumes I and II—The Technical Papers of the First Report of the National Commission on Marijuana and Drug Abuse. Superintendent of Documents, address above, $10.75 per 2 volume set (paper cover), sold in sets only, stock number 5266-0002

Drug Use in America: Problem in Perspective—Second Report of the National Commission on Marijuana and Drug Abuse, March, 1973. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, $2.60, stock number 5266-0003

Appendix to Drug Use in America: Problem in Perspective. Superintendent of Documents, address above, available in early summer of 1973

The Use and Misuse of Drugs, Stanley Einstein. Wadsworth Publishing Company, Inc., Belmont, California, 1970

Drug Abuse Information Project, Annual Reports to the Legislature, 1967-1971. Drug Abuse Information Project, University of California, San Francisco, San Francisco 94122

Love Needs Care, David E. Smith, M.D. and John Luce. Little, Brown and Company, Boston, 1971

"It's So Good, Don't Even Try It Once"—Heroin in Perspective, David E. Smith, M.D., George R. Gay, M.D., Editors. Prentice Hall, Inc., Inglewood Cliffs, New Jersey, 1972

A Doctor Among the Addicts, Nat Hentoff. Grove Press, Inc., New York, 1968

Dealing With Drug Abuse, A Report to the Ford Foundation, Drug Abuse Survey Project. Praeger Publishers, New York 1972

Society and Drugs, Volumes I and II, Richard H. Blum and Associates. Jossey-Bass, Inc., San Francisco, 1970